State EMT Continuing Education Report and Application for Re-Licensure
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
(*North Dakota EMT ONLY)*
SFN 58182 (1-06)

Date:	State License Number:	
Last Name:	First Name:	MI:
Mailing Address:		
City:	State:	Zip Code:
Home Telephone Number:	Cell Phone Number:	Work Telephone Number:
Email:	Service Affiliation:	

PRIVACY ACT NOTIFICATION

Your social security number is requested to permit the North Dakota Department of Health to verify national registration and to properly conduct a background investigation pursuant to N.D.A.C. section 33-36-01-05 before issuing a certification. Disclosure of your social security number is voluntary. However, not providing this information may result in delay of a certification due to misidentification or criminal records check requirements of state, local or federal agencies, or identification requirements of the National Registry of Emergency Medical Technicians.

Since your last re-certification or re-licensure:

☐ Yes ☐ No Have you been charged with or convicted of a felony?

☐ Yes ☐ No Have you had a health care license or certification terminated or suspended?

If you have answered "yes" to either of the above questions, please enclose a description of the event including the current status.

Part 1: EMT Basic Refresher – 24 hours*

Please attach a copy of your certificate of course completion.

Part 2: CPR Certification

Please attach a copy of your current CPR card (American Heart Association or American Red Cross).

Part 3: Continuing Education Hours							
Date	**Topic**	**Method**	**Hours**	**Date**	**Topic**	**Method**	**Hours**
					Total Hours		

Part 4: Verification of Skill Maintenance	Check Box:		
		Q/A or QI	**Direct Observation**
Patient Assessment/Management			
Ventilatory Management			
Cardiac Arrest Management			
Bleeding Control & Splinting Procedures			
Spinal Immobilization			
OB/Gyn			
Documentation and Ambulance Operations			

As Training Director of Service I hereby affix my signature attesting to the continued competence in all skills outlined in Part 4:	
Signature of Training Officer:	Date:

I attest that all information contained in this document is accurate and true. I also give the North Dakota Health Department permission to perform a criminal background check on me.	
Signature of EMT:	Date: